Nos. 89-1391, 89-1392

IN THE

Supreme Court of the United States

OCTOBER TERM, 1990

DR. IRVING RUST, on behalf of himself, his patients and all others similarly situated, DR. MELVIN PADAWER, on behalf of himself, his patients, and all others similarly situated, MEDICAL AND HEALTH RESEARCH ASSOCIATION OF NEW YORK CITY, INC., PLANNED PARENTHOOD OF NEW YORK CITY, INC., PLANNED PARENTHOOD OF WESTCHESTER/ROCKLAND, and HEALTH SERVICES OF HUDSON COUNTY, NEW JERSEY,

Petitioners,

v.

DR. LOUIS SULLIVAN, or his successor, Secretary of the United States Department of Health and Human Services,

Respondent.

THE STATE OF NEW YORK, THE CITY OF NEW YORK, THE NEW YORK CITY HEALTH & HOSPITALS CORP.,

Petitioners,

v.

DR. LOUIS SULLIVAN, or his successor, Secretary of the United States Department of Health and Human Services,

Respondent.

On Writs of Certiorari To The United States Court of Appeals for the Second Circuit

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BRIEF FOR THE NAACP LEGAL DEFENSE AND EDUCATIONAL FUND, INC., AND OTHER ORGANIZATIONS† AS AMICI CURIAE IN SUPPORT OF PETITIONERS

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PRESS OF BYRON S. ADAMS, WASHINGTON, D.C. (202) 347-8203

THE NATIONAL BLACK WOMEN'S HEALTH PROJECT, NATIONAL URBAN LEAGUE, INC., MEXICAN AMERICAN LEGAL DEFENSE & EDUCATIONAL FUND, MEXICAN AMERICAN WOMEN'S NATIONAL ASSOCIATION, NATIVE AMERICAN COMMUNITY BOARD, THE WOMEN OF COLOR PARTNERSHIP PROGRAM OF THE RELIGIOUS COALITION FOR ABORTION RIGHTS, THE BLACK, ASIAN PACIFIC, HISPANIC AND NATIVE AMERICAN CAUCUSES OF THE NATIONAL WOMEN'S POLITICAL CAUCUS, AMERICAN INDIAN HEALTH CARE ASSOCIATION, OFFICE OF CHURCH & SOCIETY OF THE UNITED CHURCH OF CHRIST, NEW YORK CITY COMMISSION ON HUMAN RIGHTS, NATIONAL INSTITUTE FOR WOMEN OF COLOR, NATIONAL MEDICAL ASSOCIATION.

QUESTION PRESENTED

(1) Whether agency restrictions on Title X family planning services that will imperil the health of poor African American women and other low-income women of color contravene Congress' intent and are, therefore, invalid?

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SUMMARY OF ARGUMENT

Amici, supporting petitioners, contend that the regulations promulgated by the Department of Health and Human Services (HHS) that prohibit pregnancy counseling and referral in Title X family planning clinics contravene Congress' intent in enacting Title X and are, therefore, invalid.

Title X of the Public Health Service Act was enacted to address a national shortage of reproductive health care services[1] for poor women. Congress

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[1] Comprehensive reproductive health care has been interpreted to be inclusive of, but not limited to: physical examinations and pap smears, contraceptive counseling and distribution, screening and/or treatment for sexually transmitted diseases and other gynecological illnesses, genetic screening, pregnancy testing and options counseling and referrals, and prenatal care. See HHS, Program Guidelines for Project Grants for Family Planning Services, (1981) at 7-16; JA at 32A-41A. (Hereinafter cited as HHS,

specifically targeted African American women and women of color as intended beneficiaries. In drafting the program, Congress placed particular significance on providing poor minority patients with non-coercive family planning information and comprehensive reproductive health services.

The challenged regulations directly conflict with this Congressional mandate. The new restrictions on counseling and referrals and the requirement that programs be physically and financially separate will reduce services for millions of low-income women, with a disproportionate share of the burden borne by women of color. The regulations will operate to limit health care in a number of ways: first, the availability of

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Program Guidelines).

health services and information to low-income women will be restricted because clinics will be forced to close; second, the quality of care received by clinic patients who are diagnosed as pregnant will be compromised; and third, poor women will be prohibited from exercising the full range of pregnancy options that are available to affluent women.

ARGUMENT

I. THE CHALLENGED REGULATIONS CONTRAVENE CONGRESS' INTENT IN ENACTING TITLE X IN VIOLATION OF THE ADMINISTRATIVE PROCEDURE ACT.

The Administrative Procedure Act authorizes a reviewing court to invalidate agency regulations that conflict with the law or that are beyond the scope of

statutory jurisdiction.[2] The challenged Title X regulations,[3] which contravene Congress' intent in enacting Title X, fall outside of the delegated power and statutory authority of the Department of Health and Human Services (HHS), and are, therefore, invalid.

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[2] The Administrative Procedure Act states, in relevant part:

> The reviewing court shall -- ...
>
> (2) hold unlawful and set aside agency action, findings, and conclusions found to be --
>
> (A) arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law; ....
>
> (C) in excess of statutory jurisdiction, authority, or limitations, or short of statutory right ....

5 U.S.C. 706. (emphasis added)

[3] Codified at 42 C.F.R. §§ 59.7-59.10 (Feb. 2, 1988).

A. Congress Intended Title X to Provide Comprehensive Reproductive Health Care for Low-Income Women and Women of Color.[4]

Title X of the Public Health Service Act was enacted in 1970 with broad bipartisan support to address a national crisis in the provision of comprehensive reproductive health care for poor women. Thus, the purpose of the Act was to ensure the availability of health information, referrals, counseling, and medical care to women who, by reason of their economic status, do not enjoy the benefits of comprehensive health care. At the time of the passage of the Act, over 5 million medically indigent women in the United States were without vital health care

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[4] The term "women of color" refers to women of African American, Hispanic or Latina, Asian/Pacific Island and Native American ancestry.

services. See 116 Cong. Rec. S. 24,089, 24,092-96 (daily ed. July 14, 1970) (Statement of Sen. Eagleton, Hart); JA at 206A-210A; 116 Cong. Rec. H. 37,365, 37,382 (daily ed. Nov. 16, 1970) (Statement of Rep. Harrington); JA at 234. Indeed, 7 out of 10 women in New York who needed family planning services were denied such services because of poverty. See 116 Cong. Rec. H. 37,365, 37,385-86 (daily ed. Nov. 16, 1970) (Statement of Rep. Harrington); JA at 237A-238A. The severity of this health crisis, and its social, economic and environmental implications, inspired Congress to overcome controversy over the question of abortion, and to create a program which would respond to the "need for non-coercive family planning services" for poor women. See 116 Cong. Rec. S. 24,089,

24,092 (daily ed. July 14, 1970) (Statement of Sen. Eagleton); JA at 207A.

In targeting the poor with this legislation, Congress recognized that Title X also necessarily and specifically targeted minority women. See 116 Cong. Rec. H. 37,365, 37,374 (daily ed. Nov. 16, 1970) (Statement of Rep. Schmitz); JA at 226A. ("The people at whom this bill is specifically aimed are the poor. . . and . . . minorities.") Noting, for example, the higher rate of poverty among non-whites, one member of Congress testified that in 1970 "the infant mortality rate among non-whites [was] three times that of whites, with a maternal mortality rate four times greater." See 116 Cong. Rec. H. 37,365, 37,380 (daily ed. Nov. 16, 1970) (Statement of Rep. Kyros); JA at 232A.

Shirley Chisholm, then a United States Representative from New York, testified at length before the Senate Subcommittee on Health about the disproportionate burden poor African American and Hispanic women bore as a result of their lack of access to adequate family planning health care. Congresswoman Chisholm noted, for example, that septic and self-induced abortions accounted for the maternity-related deaths of "only 25 percent of white women while it caused 49 percent of the [maternity-related] deaths of non-white women and 56 percent of the [maternity-related] deaths of Puerto Rican women in New York City in 1969." Hearings on S. 2108, S. 3219 Before the Subcomm. on Health, Committee on Labor and Public Welfare, 91st Cong., 1st. Sess. 195 (Dec. 9, 1969) (Statement of Rep. Shirley A. Chisholm). Sue

Randall, then migrant project coordinator for Southwest Region Planned Parenthood of Austin, Texas, attested to the desperate need for federal family planning programs to serve the predominantly Mexican-American migrant population in the Southwest. Id. at 218-219.

Congress was well aware of the critical need for adequate family planning services for poor women of color. Congressional hearings held prior to the passage of Title X amassed a wealth of evidence, including the testimony and written statements of over 30 expert and professional witnesses and over 40 medical, legal and religious oranizations. The weight of this evidence indicated that poor women in general, and women of color in particular, were in need of comprehensive reproductive health

services. See, e.g., Testimony of Cong. Ottinger See 116 Cong. Rec. 37,365, 37,386 (Statement of Rep. Ottinger); JA at 238A. Despite the continued controversy over the question of abortion,[5] therefore, Congress envisioned and drafted Title X as a unique program that would succeed where previous, less ambitious, programs had failed. Title X's broad reach contemplated the use of funds for the training of personnel, research, public education and medical care. 42 U.S.C. §§ 300 a-1, a-2 and a-3.

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[5] Congress addressed the concern expressed by some witnesses and Congress-persons that the program not fund abortion by including Section 1008 of the Act, which prohibits the use of Title X program funds "in programs where abortion is a method of family planning." 42 U.S.C. §300a-6. Prior to 1987, HHS had never interpreted this language to prohibit referrals to abortion providers.

In constructing the program, Congress placed particular significance on the provision of health information to poor women. See 116 Cong. Rec. H. 37,365, 37,387 (daily ed. Nov. 16, 1970) (Statement of Cong. Broomfield); JA at 239A. It was frequently emphasized that the information provided to Title X patients would be "non-coercive". See 116 Cong. Rec. S. 24,089, 24,092 (daily ed. July 14, 1970) (Statement of Sen. Eagleton); JA at 206A. See 116 Cong. Rec. H. 37,365, 37,389 (daily ed. Nov. 16, 1970) (Statement of Rep. O'Hara); JA at 241A; Id. at p. 37,388 (Statement of Rep. Burke); JA at 240A; Id. at p. 37,384 (Statement of Rep. Bingham); JA at 236a; Id. at p. 37,370 (Statement of Cong. Bush) JA at 222A. Congress recognized the danger of coercive family planning

services aimed at the poor, whose unique, dependent status places them in a vulnerable position, especially in the context of the insular physician-patient relationship. See 116 Cong. Rec. H. 37,365, 37,389 (daily ed. Nov. 16, 1970) (Statement of Rep. Burke); JA at 241A. Congress was careful, therefore, to ensure that the services provided would be non-coercive and respectful of "the consciences of peoples of all faiths," yet broad enough to meet the critical family planning needs of poor women. See 116 Cong. Rec. H. 37,365, 37,370 (daily ed. Nov. 16, 1970) (Statement of Rep. Bush); JA at 222A.

Although at the time of the passage of the Act abortion was legal in only four

states,[6] Congress contemplated that the information and referrals provided under Title X would include the full range of available medical options for addressing a patient's medical condition. See, e.g., 116 Cong. Rec. S. 24,089, 24,095-96 (daily ed. July 14, 1970) (Statement of Sen. Hart); JA at 209A-210A. Indeed, the legislative history reveals that Congress was particularly concerned that non-coercive information and medical counseling be provided to poor women who faced unwanted pregnancy. See, e.g., Statement of Sen. Eagleton, supra, at 24,092; JA at 206A. Congress specifically intended, therefore, that "[t]he information and educational materials

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[6] In 1970, abortion was legal in Alaska, Hawaii, New York and Washington. See, e.g., 116 Cong. Rec. H. 37,365, 37,379 Nov. 16, 1970) (Statement of Rep. Dingell); JA at 231A.

[provided as part of the program] should not be aimed at motivation, especially at motivating the person to adopt a particular ideology. . . ." Statement of Rep. Burke, supra at 37,388; JA at 240A.

B. The New Regulations Reverse Long-Standing Agency Policy And Are Inconsistent With Congress' Intent To Provide Non-Coercive, Comprehensive Health Care.

The weight to be accorded to an agency's statutory interpretation depends, in part, upon its consistency with earlier and later pronouncements. General Electric Co. v. Gilbert, 429 U.S. 125, 141-42 (1976); Skidmore v. Swift & Co., 323 U.S. 134, 140 (1944). See Saint Mary of Nazareth Hosp. Center v. Schweiker, 718 F.2d 459, 469 (D.C.Cir. 1983); United Transportation Union v. Lewis, 711 F.2d 233, 242 (D.C.Cir. 1983). HHS' decision, in 1987, to prohibit Title X-funded

doctors from discussing the abortion option with their patients and from providing referrals for such services, constituted an abrupt reversal of agency interpretation. This reversal directly conflicts with Congress' intention that poor women be provided with comprehensive reproductive health care. As such, these new regulations fall outside HHS' delegated authority and are owed no deference.

For the first seventeen years of the program's operation, the administering agency, first the Department of Health, Education and Welfare (HEW), and now HHS, interpreted Congress' mandate that non-coercive information and services be provided to Title X patients to include information about abortion services, where indicated. HHS, Program Guidelines,

supra. Suddenly, without any direction or concern being raised by Congress, the agency has rewritten its regulations to exclude counseling and referral about the abortion option.

The political controversy which has spawned the new HHS regulations was not unforeseen by Congress. From the outset, Congress recognized that strong and clear direction from Congress to the administering agency would be necessary to the success of Title X as a non-coercive, comprehensive "health-care service mechanism." Statement of Rep. Bush, supra, at 37370; JA at 222A; Statement of Rep. Hawkins, supra at 37370; JA at 222A; Several Congressmen acknowledged that family planning "health services to the poor ha[d] been grossly mismanaged in the past" by the agency. Statement of Rep.

Bush, supra, at 37,371; JA at 223A. One sponsor of the Act, Congressman Scheuer, expressed open distrust of the agency's capacity to administer the program in accordance with the letter and spirit of Title X that was intended by Congress. Despite the testimony from then HEW Secretary Elliot Richardson in support of the legislation, Congressman Scheurer pointed out that it was Congress, not HEW, which "consistently led the way in lifting the curtain of controversy from family planning," and "forced the Department to face its responsibilities." Statement of Rep. Scheuer, supra, at 370; JA at 222A. Congressman Scheurer predicted that Congress would need "to continuously exercise the maximum degree of legislative review and moral leadership" to ensure that the success of the program was not

undermined by political pressure and agency mismanagement. Id.

Despite 17 years of consistent and conscientious interpretation of the Act by HHS in accordance with Congressional intent, HHS has now proved the accuracy of Congressman Scheuers' prediction. HHS' actions infuse political and religious beliefs into Title X by requiring that providers deny their patients information about the full range of medical options for dealing with pregnancy. The disastrous results these regulations will have on the integrity of Title X-funded programs, and on the health of the poor women who use them, demonstrates the new regulations' flagrant conflict with Congress' intent.

C. The Challenged Regulations Will Result In a Dual System of Health Care Which Will Imperil the Health of Poor Women, A Disproportionate Number of Whom Are African American And Other Women of Color.

The new regulations will directly limit access to basic health care for the millions of poor women who rely on federally funded family planning services, thereby contravening the program's congressional mandate.

Congress indicated that Title X was specifically aimed at eradicating a dual system of health care for poor and wealthy women. See PPFA v. Bowen, 680 F. Supp. 1465, 1469 (D. Colo. 1988) (Title X designed to eliminate a two-tiered system of delivery of family planning services). In the committee report accompanying the final House version of the Title X bill, Congress acknowledged that the lack of

free family planning services "deprives low-income women of the right to effectively plan their families, a right long enjoyed by more affluent couples. This form of discrimination, based on economic status, has many unfortunate health, social and financial consequences for the individual family and the society." H.R. Rep. No. 1472, 91st Cong., 2d Sess, reprinted in 1970 U.S. Code Cong. and Admin. News at 5074; JA at 252A. HHS' promulgation of regulations that deliberately foster ignorance about medical options and compel physicians to provide substandard health care to poor women is "an attempt to coerce or 'punish' the poor," in direct conflict with Congress' intended purpose in enacting the statute. 116 Cong. Rec. 37,263, 37,389 (1970); JA at 241A. 116 Cong. Rec. H.

37,365, 37,389 (daily ed. July 14, 1970) (Statement of Rep. Burke); JA at 241A.

Low-income women and teenagers at risk of pregnancy, a disproportionate number of whom are African American and other women of color, often have greater problems than higher income and older women in obtaining medical care. Poor and young women simply cannot afford medical services and often have less experience or knowledge about how to navigate the fragmented American health care system. Clinics that rely on Title X funds, in whole or in part, often provide the only continuous health care that poor women, particularly the uninsured, may receive.[7]

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[7] HHS itself has acknowledged that "[f]or many clients, family planning programs are their only continuing source of health information and medical care." HHS Program Guidelines, supra, at sec. 9.4 (39A). See also HEW, A Report on Family Planning Services and Population Research

Additionally, Title X clinics are currently relied upon by their patients to provide a wide range of health information and referrals that are otherwise unobtainable in low-income communities. Other types of health care, such as infant care, teen counseling, high risk pregnancy care, and abortion services, are often provided by programs located in the same facility as the Title X family planning service. See, e.g., Morgan Aff. at ¶ 1.

Because African American and other women of color are overrepresented as clinic patients, they will be severely disadvantaged by any limitations imposed on family planning clinics.

The challenged regulations will limit the health care that Title X provides in several ways: the availability of health

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18 (Dec. 1978) (309A).

services and information to low-income women will be restricted because a number of clinics will be forced to close; the quality of care received by clinic patients who are diagnosed as pregnant will be compromised by the prohibition on counseling about their options; and the lives and well-being of those women for whom abortion may be medically indicated will be jeopardized by the lack of information.

Significantly, the regulations will disadvantage and limit health care services only for the poor. Affluent women, capable of paying private doctors for medical care will continue to have access to information about the full range of pregnancy options, including abortion, while poor pregnant women and adolescents will be denied access to such basic

information and will be uninformed about the abortion option.

Moreover, affluent women will be able to make decisions regarding their pregnancies in consultation with their physicians based on reasoned, impartial and complete information about medical options, as currently required by federal and state law, as well as medical ethical guidelines. See Morley Aff. at ¶¶ 18-22; JA at 664A-666A. Rosenfield Aff. at ¶¶ 7, 23; JA at 679A, 689A. Women able to pay for private physicians will be able to make their health decisions free from government mandated coercion by physicians.

Poor pregnant women, on the other hand, will always be steered toward childbirth by Title X providers. These health professionals will be compelled by the new

regulations to provide all pregnant women with only prenatal care information and referrals, irrespective of the patient's physical or emotional condition, and without regard for the attending physician's best medical judgment.

Congress did not intend such a result when Title X was enacted.

1. The challenged regulations will result in fewer health care resources and substandard medical care for low-income African American and other women of color, thereby endangering their health.

Under 42 CFR § 59.9 of the new regulations, federally funded clinics will be required to separate their Title X programs physically as well as financially from any non-federally funded program that provides abortion counseling, referrals or services. Title X-funded clinics may be, at the Secretary's discretion, prohibited

from sharing office space, buildings, telephones, staff or medical records with programs providing abortion services or engaged in abortion-related activities. Not only will the regulations serve to fragment the comprehensive health care scheme envisioned by Congress, but for most clinics, the expense of establishing a separate facility with separate staff will be prohibitive.

The regulations will force many organizations that receive Title X funds into one of the following options: eliminate either the family planning program or the program that offers abortion counseling; lose federal funding altogether, jeopardizing financial stability and continued operation; or cease to operate entirely. See Morley Aff. at ¶¶ 7-8; JA at 660A-661A. Each of

these options will result in a devastating loss of health care to low-income communities that can ill-afford any reduction in services.

In affidavits filed in proceedings in the Second Circuit and other jurisdictions, health practitioners and program directors have stated that it is not economically feasible to operate separate facilities for family planning services and for abortion services.[8]

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[8] Moran Affidavit, at ¶8; (The loss of these funds, constituting 50% of our family planning budget at the Bronx Center would compel a drastic reduction in services to low-income women in the South Bronx.") Affidavit of Margie F. Hale, Exec. Dir., The Women's Health Center of West Virginia, Inc., West Virginia Association of Community Health Centers v. Sullivan, C.A. 2:89-0330 (S.D.W.V.) ("[I]f Title X regulations ban the co-location of family planning services and abortion services, the Center would terminate its family planning services.") See Appendix at 35a at ¶8; Affidavit of Bruce Berry, M.D., Vice Chairman of the West Virginia

Section of District 4 American College of Obstetricians and Gynecologists, West Virginia Association of Community Health Centers v. Sullivan, C.A. 2:89-0330 (S.D.W.V.) ("[T]he ramifications of the implementation of the regulations are especially devastating to the obstetrics and gynecological community in West Virginia in that in the last five years the number of obstetricians and gynecologists in West Virginia has been greatly reduced from 130 to 80. The regulations would place a heavy burden on the remaining obstetricians and gynecologist in West Virginia because it would force many Centers to close and encourage competent physicians to leave the State.") See Appendix at 21a ¶8; Affidavit of Leslie Tarr Laurie, Exec. Dir. of Family Planning Council of Western Massachusetts ("FPCWM"), Commonwealth of Massachusetts v. Bowen, 679 F. Supp. 137 (D. Mass. 1988), aff'd, 899 F.2d 53 (1st Cir. 1990) ("[I]f Title X regulations banned the co-location of family planning with abortion services, FPCWM would be forced to terminate family planning services in two geographical areas because it would not be economically feasible to open separate facilities.") See Appendix at 45a, ¶8; Affidavit of Diane M. Booth, Exec. Dir., Planned Parenthood of Central Missouri ("PPCM"), Commonwealth of Massachusetts v. Bowen, 679 F. Supp. 137, aff'd, 899 F.2d 53 (1st Cir. 1990) ("In the event that total separation of services is required at the Columbia clinic [the only facility providing first

Furthermore, many providers have stated that they would cease practicing for ethical reasons, if prohibited from giving complete and comprehensive medical information to pregnant patients. Drisgula Aff. at ¶ 30; Felton Aff. at ¶ 13(c); O'Hora Aff. at ¶ 14.

a. African American and other women of color are overrepresented among Title X patients and will be disproportionately affected by any decline in services.

This Court has long played an important role in the protection against administrative intrusion on the interests of the disadvantaged. See Yick Wo v. Hopkins, 118 U.S. 356 (1886); United States v. Carolene Products Co., 304 U.S.

trimester abortion services between Kansas City and St. Louis], it is likely that PPCM would opt not to receive Title X funding, thereby reducing the opportunity for low-income people to receive family planning services.") See Appendix at 26A, ¶13.

144, 152, n.4 (1938). Indeed, administrative regulations which impinge upon areas of judicial concern -- whether or not the restriction or violation has risen to a constitutional level -- are entitled to a lesser degree of judicial deference and are subject to greater examination. See e.g., Green v. McElroy, 360 U.S. 474, 508 (1959); United States v. Weller, 401 U.S. 254, 257 (1971). Where, as in this case, an administrative agency's action will disproportionately and significantly affect the interests of poor African American and other women of color, and that action was not authorized by Congress, the agency's action should be found invalid.

Title X health services are a primary source of health care for African American and other poor women of color. See Tiezzi

Aff. at ¶ 8(a) JA at 726A-727A African American women make up only 12.9% of all women of reproductive age (15-44 years),[9] but in 1983, they represented 26% of all family planning clinic patients. The Alan Guttmacher Institute, Organized Family Planning Services in the United States, 1981-1983, at 29 (1984) (hereinafter cited as Guttmacher, Organized.) In 1988, an estimated 3.74 million women used a Title X clinic in their last family planning visit during the previous 12 months; of these, 28.1% were African American and 3.2% were other women of color. Mosher, W., Use of Family Planning Services in the

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[9] Latina women are 7.5% of women of reproductive age, other women of color 3.1%, and white women 76.5%. Forrest, J., Gold, R., and Kenney, A., The Need, Availability and Financing of Reproductive Health Services 3, The Alan Guttmacher Institute (1989) (hereinafter cited as Forrest, The Need.)

United States: 1982 and 1988, at 4, from Vital Health Statistics of the National Center for Health Statistics, No. 184 (April 1990) (hereinafter cited as Mosher, Use.) In 1988, 53% of African American women and only 32% of white women used a clinic for their most recent family planning visit. Id. at 2-3.

African American women are most likely to rely on clinics for family planning services because they are less likely than white women to have health insurance coverage, sufficient income to pay the fees of private doctors, or a regular source of medical care. Id. at 3 and n.4. Overall, 22% of African American and 33% of Hispanic, Asian/Pacific Island and Native American female heads of families are uninsured, compared to 15% of white female heads of families. Children's

Defense Fund, Black and White Children in America: Key Facts 27-29 (1985) (hereinafter cited as CDF, Key Facts.) Further, in 1986, 26.4% of African American children under age 18 were uninsured, compared to 17.5% of white children of the same age who were uninsured.

Indeed, while low-income women in general were much more likely than higher income women to rely on clinics for their family planning services, African American women of all incomes relied heavily on these services. For example, in 1988, 60% of all low-income women used clinics for their most recent visit, compared with only 27% of all women with incomes of 150% of poverty or more, while among African American women, 67% of low-income and 41% of higher income African American women

used family planning clinics. Mosher, Use, supra, at 3-4.

b. The new regulations will reduce services for low-income women and teens who lack health coverage and rely on family planning clinics.

Access to health care is determined by one's economic and employment status. Nonelderly individuals and families who rely on public benefit programs, such as Aid to Families with Dependent Children (AFDC) for their sole source of income are eligible for medical coverage through the federally funded Medicaid program.[10] Among women aged 15-44, with family incomes below the federal poverty standard, four in ten depend on Medicaid for access to medical care. Fewer than one in ten women with slightly higher incomes (100-199% of

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[10] See, 42 U.S.C. §§ 1396 et seq. 1982 ed.

poverty) and only two percent of higher income women are covered by Medicaid or other public programs. Forrest, The Need, supra, at 18. Regrettably, more than one-third of women between 15-44 years of age and below 100% of poverty have no health insurance coverage. Id. Among teenaged women aged 15-19, 20% are not covered by insurance. Id. Congress intended the Title X program to serve the many low-income women who cannot afford alternative sources of health care.[11]

Nationwide, in 1983, an estimated 83% of family planning program patients had low incomes (below 150% of poverty), including 13% who received public assistance. Guttmacher, Organized, supra,

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[11] Under the Act, low-income patients are to receive free services, 42 U.S.C. § 300a-4(c), and charges for others are determined by family income on a sliding fee basis.

at 25. AFDC recipients often use Title X-funded family planning clinics, as well as private doctors who accept Medicaid patients for contraceptive and general medical services and referrals.[12]

An estimated 1.6 million women under

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[12] Studies have shown that even when Medicaid is made available to those who need assistance, many physicians and providers are unwilling to accept Medicaid eligible patients, due to lower than private pay reimbursement rates, bureaucratic red tape, and other factors. G. Dallek, Health Care for America's Poor: Separate and Unequal, 20 Clearinghouse Rev. 361, 366 (1986)(citing studies).

HHS recognizes the disproportionate dependence of people of color on federally funded health care services. HHS has noted that certain health care providers' policies that limit access to care based on patients' status as Medicaid recipients may have a disproportionate racial impact in violation of Title VI of the Civil Rights Act of 1964, 42 U.S.C. §2000d. See Internal Memorandum, U.S. Dept. of Health, Education, and Welfare, Office of Civil Rights, from David F. Chaukin to Carolyn Russell (Dec. 11, 1980). Such impact is certainly present in this case, because of the heavy reliance of women of color on Title X-funded programs.

age 20 obtained family planning services from organized clinics in 1983, constituting more than 30% of all clinic patients. Guttmacher, Organized, supra, at 28. African American teenagers, in particular, rely heavily on clinic services. In 1988, 40.9% of all African American teenagers aged 15-19 had visited a family planning clinic within the last 12 months. Mosher, Use, supra, at 2.

African American teens are twice as likely as white teens to become pregnant.[13] Seventy-three percent of all pregnancies to African American teens between the ages of 15 and 19 were unintended in 1980, compared with 63% of unintended

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[13] CDF, Key Facts, supra, at 39. Teenage births accounted for approximately one-quarter of all births to African American mothers and 12% of all births to white mothers. Id. at 38.

pregnancies among white teens.[14] Of 10,200 births to mothers under age 15 in 1986, 58% of the mothers were African American, 39% white and 13% Hispanic. Children's Defense Fund, A Vision for America's Future: An Agenda for the 1990's: A Children's Defense Fund Budget 93 (1989) (hereinafter cited as CDF, A Vision.) An essential prevention strategy for those teens who are sexually active is access to contraceptive services and counseling. If the challenged regulations are approved, African American teens will suffer disproportionately from reduced access to clinics and contraceptive information and services.

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[14] Thirty-nine of 100 African American teens with unintended pregnancy actually have a baby, compared with 25 out of 100 white teens. CDF, Key Facts, supra, at 39.

2. The requirement that services be segregated will impede the provision of care to intended beneficiaries.

The requirement that various family planning services be segregated will result in delayed or no follow-up services for many patients. Moreover, for poor women the segregation of services will mean incurring the often prohibitive expense of traveling to additional locations for needed health care. Most importantly, as stated above, many clinics will be forced to close because of the additional costs associated with physically separating related services. See Moran Aff. at ¶ 8.

The closure of clinics and even the elimination of existing programs will reduce access to abortion services, prenatal care and other vital medical services for clinic patients. In sum, the

physical segregation of family planning from abortion-related services will serve to disadvantage the very population that Title X is designed to serve and will compromise the health care provided by the clinics. Congress did not intend such a result.

3. The counseling and referral prohibitions of the new regulations will undermine the provision of reproductive health care to all pregnant patients and may endanger the lives of African American and other women of color with serious health conditions.

The new Title X regulations will have an adverse effect on the health of poor pregnant patients, whether or not they wish to terminate their pregnancies. Clearly, under the new regulations, women of color will be steered away from abortion. Without a referral from the Title X clinic, some women will be unable

to locate and obtain abortion services until later, more dangerous stages of pregnancy. Indeed, the mortality risk for abortion increases 50 percent with each week after the eighth week of pregnancy, and the risk of major complications in the procedure increases by approximately 30 percent per week. See Morley Aff. at ¶12; JA at 662A. See also Grimes, Second-Trimester Abortions in the United States, 16 Fam. Plan. Persp. 260-265 (Nov./Dec. 1984). The dangers are particularly acute for adolescents, who most often postpone pregnancy confirmation and abortion until the second trimester of pregnancy. See Henshaw Aff. at ¶14; Morley Aff. at ¶ 12.

Without adequate information, other clinic patients will self-induce abortion or seek illegal back street abortions at great risk to their life and health. In

1970, prior to the enactment of Title X, it was reported that "botched abortions [were] the single largest cause of maternal deaths in the U.S." Statement of Rep. Chisholm, supra, at 195.

Even pregnant patients who wish to carry pregnancy to term will be injured by the new regulations. Early prenatal care is the key to ensure a healthy and safe pregnancy for both the mother and child.[15] A lack of prenatal care can result in low-birth weight babies,[16] infant mortality,[17]

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[15] Gold, R., Kenney, A., and Singh, S., "Paying for Maternity Care in the United States" 19 Family Planning Perspectives 190 (No. 5, Sept./Oct. 1987).

[16] Low birth weight is defined as less than 5.8 pounds and is a leading cause of infant death. Small babies who survive face an increased risk of being impaired for life by autism, retardation, cerebral palsy, epilepsy, learning disabilities and vision or hearing loss. CDF, A Vision, supra, at 38.

In 1982, 6.2% of all Native American

and maternal mortality.[18] Yet the challenged regulations interfere with the kind of integrated services that

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babies born were of low birth weight, compared to 6.9% of all Filipino babies, 9.1% of all Puerto Rican babies, 12.4% of all African American babies and 5.6% of all white babies. HHS, Office of Minority Health, Closing the Gap, "Infant Mortality, Low Birth Weight and Minorities" 1 (1988).

[17] In 1987, the infant mortality rate per 1,000 live births was 5.4% for Asians, 7.9% for Hispanics, 8.6% for whites, 9.9% for Native Americans and 17.9% for African Americans. National Commission to Prevent Infant Mortality, Troubling Trends: The Health of America's Next Generation 20 (1990).

[18] In 1986, African American women were 3.8 times more likely to die from pregnancy causes than white women. Non-white women were 3.3 times more likely to die from pregnancy related causes than white women. The leading causes for these maternal deaths are considered "preventable or probably preventable through routine medical care before pregnancy, early and continuous prenatal care, risk appropriate delivery procedures, and routine care after birth." Children's Defense Fund, The Health of America's Children: Maternal and Child Health Data Book 10 (1989).

facilitate enrollment in family planning and counseling programs.

The new regulations expressly state that once a patient is diagnosed as pregnant, she is no longer eligible to receive Title X subsidized services. 42 CFR §59.8 (a)(2).

Although it is uniformly accepted that responsible pregnancy testing must include options counseling, particularly when the pregnant patient is an adolescent,[19] the new regulations prohibit such counseling and referrals.[20] Under the new

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[19] See, e.g., Morgan Decl. at 653A.

[20] Dr. Joseph D. Beasley, who testified before the Senate Subcommittee on Health, and whose study on the success of the Louisiana Family Planning Program was cited with approval by almost every Congressperson who testified in support of Title X, listed "referral to other medical services" as an essential component to any successful family planning program. Hearings on S. 2108 Before Subcomm. on Health of the Senate Comm. on Labor and

regulations, the patient may receive only a list of prenatal care facilities and general information about the preservation of fetal life. 42 CFR §59.8(2).

Limiting the information that pregnant patients may receive will delay poor women in obtaining prenatal care and in locating alternative services. Under current practice, most Title X providers immediately refer pregnant patients who wish to carry to term to a prenatal care service, often located in the same building as the family planning program. See Rust Decl. at 699A, Bennett Decl., at 495A, Tiezzi Decl. at 725A. In many cases, the Title X health provider will make the first prenatal care appointment for the patient to ensure that the patient

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Public Welfare, 91st Cong., 1st Sess. (Dec. 8, 1969) at 77.

follows through with care. The new regulations forbid this type of assistance.

Title X providers will not be permitted to inform pregnant patients which facilities in their professional judgment are superior. Because of her pregnancy, the poor woman or teen must be virtually abandoned by the Title X provider, even if she has enjoyed an ongoing relationship with the program as a family planning or counseling patient.

The mere provision of a list of prenatal care facilities is inadequate to ensure that pregnant adolescents will obtain prompt prenatal care. See, e.g., Tiezzi Decl. at ¶ 8(a)-(c); JA at 726-28A. In fact, providing such a list without additional counseling and information will almost always result in

delaying the adolescent's enrollment in a prenatal care program. Teens are often ill-equipped to navigate complicated social services systems, and are most prone to delay seeking follow-up health care. See Bennett Aff. at ¶ 12. JA at 498A. Impressionable teens who experience unintended pregnancy need nonjudgmental counseling "to inform them of all their options for pregnancy resolution and the associated risks and benefits of each -- abortion, parenthood, and adoption." National Academy of Sciences, Risking the Future, 1-2 1987.

For many pregnant adolescents who wish to carry their pregnancies to term, time is of the essence. Pregnant adolescents often suffer particular physical, social, and economic consequences of pregnancy. See Rosenfield Aff. at ¶ 17(a). For

example, maternal mortality, toxemia, anemia, premature childbirth and low birthweight occur at significantly higher rates for pregnant women under the age of 15 as compared to those 20-24 years of age. See Morley Aff. at ¶ 6; JA at 685A. Rosenfield Aff. at ¶ 17; JA at 685A. Medical risks are increased by the delay in prenatal care that the new regulations will create. See, e.g., Bennett Decl.; JA at 500A.

Lack of prenatal care is a particularly serious problem for poor African American and Hispanic communities. African American babies are twice as likely as white babies to be born to mothers who received late prenatal care or delivered their babies without having ever had a prenatal examination. CDF, Key Facts, supra, at 76. Almost one African American

baby out of ten is born to a mother who received late or no prenatal care. Id. Among African American teenage mothers under age 15, the proportion increases to two in ten. Id. Nearly 13% of Hispanic babies are born to mothers who received late or no prenatal care, compared to 4% of white babies.[21]

a. A disproportionate number of African American and other women of color suffer from serious health conditions that are exacerbated by pregnancy and will be at great risk under the new regulations.

Limiting the information that pregnant patients receive may have fatal consequences for patients who suffer from diseases that are exacerbated by pregnancy. African American and other women of color suffer disproportionately

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[21] Children's Defense Fund, The Health of America's Children: Maternal and Child Health 13 (1988).

from a variety of serious health conditions, such as high blood pressure, hypertension,[22] diabetes,[23] and certain forms of cancer,[24] which may be exacerbated by pregnancy. These women will face long-term health risks, or even death, when

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[22] Of women ages 25-44, from 1979-81, hypertension was prevalent 2.6 times more often in African American women than in white women. HHS, I Report of the Secretary's Task Force on Black and Minority Health 75 (1985) (hereinafter cited as HHS, Task Force.)

[23] HHS, Task Force, supra, at 75. African American women have a 50% greater incidence of diabetes than their white female counterparts. Native American women are ten times more likely than white women to have diabetes. Hispanic women who reside in poor urban areas or barrios were four times more likely to become diabetic than Hispanic women who reside in the suburbs. HHS, Office of Minority Health, Closing the Gap, "Diabetes and Minorities" 2 (1988).

[24] African Americans, Hawaiians, Chinese, and Native Americans are at the greatest risk for cervical cancer. Id. at 3.

Title X health practitioners fail to counsel them about the options for handling the risks of a continued pregnancy.

In some cases, continuation of pregnancy for women suffering from these illnesses may carry grave health consequences for both mothers and their fetuses. Chronic hypertension, for instance, may lead to a stroke during pregnancy.[25] In fact, hypertension is associated with up to 30% of maternal deaths and up to 22% of perinatal deaths.[26]

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[25] Stroke deaths are higher among African Americans than among whites. HHS, Task Force, supra, at 110. See, Rosenfield Aff. at ¶11; JA at 683A.

Both hypertension and diabetes can be controlled with proper medical treatment. Id. at 74. Nonetheless, hypertension accounted for more than 5% of excess African American deaths. Id. at 74.

[26] Task Force at 110. Rosenfield Aff. at ¶11; JA at 683A.

Pregnant diabetics run the risk of exacerbating debilitating vascular changes. See Rosenfield Aff. JA at 683A.

Certain forms of cancer are also more prevalent among women of color than whites. The mortality and incidence rates for cervical cancer, for example, are approximately 2.5 times higher for African American women than white women. HHS, Task Force supra, at 92. Continued pregnancy for these women may be life threatening.

Pregnant women with sickle cell anemia, a disease endemic to people of African descent,[27] may go into sickle cell shock and die as a result of pregnancy. Rust Decl. at ¶17 (a)-(b); JA at 705A-706A.

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[27] 50,000 African Americans have sickle cell anemia. Association for Sickle Cell Services Education Research and Treatment, Inc. Sickle Cell Anemia: A Family Affair (1988).

Perinatal mortality and spontaneous abortion are also risks to pregnant sickle cell patients. Rosenfield Aff. at ¶ 14; JA at 684A. Failure to provide such patients with the full range of information and options related to their medical condition and their pregnancy violates the most basic standards of medical practice.

Pregnant women who are HIV-positive must also be apprised of the full range of pregnancy options and provided with more than a referral list to prenatal care providers. Tragically, Acquired Immune Deficiency Syndrome (AIDS) has disproportionately impacted women of color and their newborn infants. The incidence of AIDS in Latina women is almost 11 times

that of white women.[28] Women account for 13% of all Latino AIDS death since 1980.[29] Fifty-two percent of all women with AIDS are African American, as are 59% of all children with AIDS under thirteen years old.[30]

A pregnant patient must be told of the risks to her health and to that of her child, particularly since pregnancy may accelerate the progression of HIV disease, AIDS and AIDS-related complex. See Minkoff Aff. at ¶7; Rust Decl. at ¶17(a); JA at 705A. A pregnant woman who tests HIV-positive should be counseled on how to protect herself and her partner. In some

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[28] Worth, D. and Rodriguez, R., "Latina Women and AIDS," SIECUS Report Jan.-Feb. 1987 at 5.

[29] Id.

[30] Weston, G., "AIDS in the Black Community," Au Courant, Fall 1986.

cases, it may be appropriate for the health provider to arrange an appointment for the patient at the appropriate referral agency, and provide the patient with information about support groups. The new Title X regulations contemplate abandoning such a patient, because as a pregnant woman, she is ineligible for Title X services.

Restrictions on the dissemination of medical information to poor women with grave health problems who use Title X facilities is particularly harmful since these women lack alternative sources of reliable health information. Withholding critical health information from poor pregnant women will sentence some women to death and others to long term health problems.

CONCLUSION

For the foregoing reasons, the judgment of the Second Circuit should be reversed.

Respectfully submitted,

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July 27, 1990

APPENDIX

INTEREST OF AMICI CURIAE

THE NAACP LEGAL DEFENSE & EDUCTIONAL FUND, INC. ("LDF") is a non-profit corporation formed to assist African Americans to secure their constitutional and civil rights and liberties. For many years LDF has pursued litigation to secure the basic civil and economic rights of low-income African American families and individuals. Litigation to ensure the non-discriminatory delivery as well as the adequacy of health care and hospital services available to African American communities has also been a long-standing LDF concern. See e.g., Bryan v. Koch, 627 F.2d 612 (2d Cir. 1980) (Challenging the closing of Sydenham public hospital in Harlem under Title VI of the Civil Rights Act of 1964). LDF has also worked on

behalf of African Americans struggling with the burden of poor health and discriminatory and inadequate healthcare services.

LDF is particularly concerned with the growing rates of poverty among African Americans and with the number of single female-headed African American families that are living in poverty. LDF's Black Women's Employment Program strives to remove obstacles to employment in occupations where African American women are underrepresented and to provide access to jobs with better wages, decent comditions, and pension and health benefits. Health care for low-income uninsured women and their families is a matter of great concern to LDF. Through its Poverty & Justice Program, LDF is challenging the barriers to economic

advancement to help to improve the economic status and living conditions of the many in poverty.

This case implicates the full panoply of these important LDF concerns. It involves constitutional and statutory challenges to new regulations which prohibit federally-funded family planning clinics from providing abortion information services and referrals. These clinics' services are restricted to low and moderate income persons, a disproportionate number of whom are African American or are other women of color.

Limitations on the types of reproductive information and services provided by these clinics will disproportionately limit the range of reproductive options available to women of

color. This in turn will increase the number of unwanted pregnancies and promote continuing cycles of poverty and despair, while creating unnecessary medical risks for women of color.

For these reasons, LDF has filed this brief Amicus Curiae in support of petitioners' challenges to the validity of the new Title X regulations.

* * *

THE MEXICAN AMERICAN LEGAL DEFENSE AND EDUCATIONAL FUND (MALDEF) established in 1967, is a national civil rights organization headquartered in Los Angeles. Its principle objective is to secure, through litigation and education, the civil and constitutional rights of Hispanics living in the United States. Fundamental among those rights is the right to privacy which encompasses the

right to choose in matters of family planning. That right to choose is at issue in this case for the vast numbers of low income Hispanic Women who rely on federally-funded family planning clinics.

* * *

THE NATIVE AMERICAN COMMUNITY BOARD, of South Dakota, works for the advancement of Native American women by working on issues pertinent to health education, economic development, and treaty rights. The NACB also organizes women in self-help development and coalition building concerning reproductive rights. The NACB is a reservation based organization working with Native women locally, regionally, nationally and internationally. The NACB serves reservation based Native American women.

We promote equality of health care, access to health care and believe that Native American Women should have access to true and concise information in order to be able to make appropriate decisions regarding their lives. By denying or withholding certain information to women can only compromise a life. Native American women suffer with high rates of diabetes, high blood pressure, TB, and other conditions which are life threatening especially when complicated with pregnancy.

* * *

THE NATIONAL URBAN LEAGUE founded in 1910, is the premier social service and civil rights organization in America. The League is a non-profit, community based agency headquartered in New York City, with 114 affiliates in 34 states and the

District of Columbia. Its principal objective is to secure equal opportunity for African-Americans and other minorities in every aspect of American life. The National Urban League supports full access to comprehensive reproductive health services for African-American women and their families. The Title X Program also represents a key source of primary health care for low-income African-American women.

* * *

THE BLACK, ASIAN PACIFIC, HISPANIC, AND NATIVE AMERICAN CAUCUSES OF THE NATIONAL WOMEN'S POLITICAL CAUCUS is a bi-partisan, grassroots, membership based organization dedicated to political representation and full participation of all women in government and community life. The Asian Pacific, Black, Hispanic

and Native American Caucuses are deeply concerned with women's fundamental right to choose abortion, particularly women in poor communities who already suffer from inadequate and restricted access to health care services.

* * *

THE WOMEN OF COLOR PARTNERSHIP PROGRAM OF THE RELIGIOUS COALITION FOR ABORTION RIGHTS, located in Washington, D.C., is a national effort to educate women of color concerning public policies surrounding the issue of reproductive choice and its disproportionate affect on women of color. As the injustices of racism, sexism and classism engulf the day-to-day choices available to African-American, Latin American, Native American and Asian/Pacific American women, access to reproductive health care affectrs every

element of our lives. This program seeks to identify and address not only reproductive rights issues but also reproductive health care concerns from the unique perspectives of women of color to include: (1) the right to choose or not to choose abortion; (2) family planning and all methods of birth control; (3) teen pregnancy; (4) prenatal care; (5) child care; and (6) medical abuses against women of color.

This organization is extremely concerned about the continued existence and perpetuation of illegal abortions, sterilization abuse, forced Caesarian sections, the use of Depo-provera, and the lack of sufficient prenatal care for women of color. The economics of this country dictates that the "haves" may choose to purchase whatever health services they may

need or want. The "have nots" hold very few choices in their lives and in many instances must rely on the federal government. We are concerned about the numerous public policies which create a negative impact on the ability of women of color to make a difficult decision, the unnecessary sacrifices that she and her family may have to make because of a lack of resources and the degradation that she must undergo to carry out her decision. We believe that all women, regardless of race or class, should have access to a safe and legal abortion. Lastly, we believe that the right to choose abortion is a personal decision to be respected and made in consultation with a woman's doctor, her family with spiritual guidance but without governmental interference.

* * *

THE AMERICAN INDIAN HEALTH CARE ASSOCIATION promotes the health status of Native Americans by supporting overall improvement of health care. AIHCA represents 36 urban Indian health programs, which provide health services to Native Americans living in urban areas. Native American women are amongst the poorest groups in the nation. Financial barriers to health care have contributed to decreased access and poorer health. It is important that Native American women retain options in their pre-natal health care and family planning activities. High rates of teenage pregnancy and concommitantly, increased infant mortality can only be exacerbated by decreased access to Title X funded program.

* * *

THE MEXICAN AMERICAN WOMEN'S NATIONAL ASSOCIATION of Washington, D.C. is committed to improving the quality of life for all Hispanic women.

* * *

UNITED CHURCH OF CHRIST OFFICE FOR CHURCH IN SOCIETY. Standing in the Hebrew Christian tradition we affirm God as the server of life, our life, all life, life to the fullest. She has called us to share the world of Creation with her, giving us the privileges and responsibilities of fellowship in the wider units of society. Thus, we affirm the freedom with which God endowed men and women, but we affirm and receive this as a freedom bound to responsibility. At its best our Western legal tradition as well, has served the dual purpose of protecting human freedom and helping human beings to

discharge their responsibilities to one another.

Our religious heritage has also stressed reverence for human life. Accordingly, the enhancement of human life and the protection of the rights of persons, particularly those who are oppressed because of their race, sex or class. As an agency of the United Church of Christ, we find it neither likely or desirable that organized society would disavow its responsibility in this regard.

* * *

THE NATIONAL INSTITUTE FOR WOMEN OF COLOR (NIWC) is a non-profit, public interest organization dedicated to helping women of color achieve equity in all aspects of U.S. society, most particularly in educational attainment and economic achievement. Women of color (i.e.,

Hispanic, African American, Asian American, Pacific Islander, American Indian, or Alaska Native) are disproportionately represented among low-income and public assistance clients and, therefore, have little option but to use publicly funded family planning clinics. Women of color, disadvantaged by economic status caused by race/ethnicity and gender discrimiantion, are disadvantaged again when pregnancy is diagnosed in a clinic funded under Title X. Moreover, because this population often suffers from poor nutrition, unattended health conditions, and multiple disabilities (hypertension, Sickle Cell Anemia, for example), the risk of carrying a pregnancy full-term may endanger the mother's life. Certainly, the potential of greater economic distress brought on with the unintended birth of a

child is another type of hazard. In effect, the restrictive regulations for Title X place women of color in the greatest jeopardy. NIWC recognizes this jeopardy as an issue related to its mission and thereby wishes to lend its support through the amicus brief.

* * *

THE NATIONAL BLACK WOMEN'S HEALTH PROJECT is a health, education and advocacy organization that works to improve the quality of life for African American women. It works to promote non-discriminatory approaches to insure that all African American women have access to health services, including abortion, that maximize maternal health, reduce infant mortality and produce healthy babies. Because poor African American women are particularly vulnerable to economic

hardship, the impact of restrictions on health services will be particularly severe for them.

* * *

THE NEW YORK CITY COMMISSION ON HUMAN RIGHTS ("The Commission") is a local administrative agency charged with eliminating all prohibited forms of discrimination within the City of New York, including race, national origin and age discrimination in access to health services. N.Y.C. Admin. Code Sec. 8-101 et seq. The Commission adjudicates claims of discrimiantion in access to pblic accommodations under local law.

The Commission takes seriously its public charge that all women in New York be afforded full access to quality health services free from discrimination on the basis of race, national origin and age.

Thus, the commission is deeply concerned about the ways in which restrictions on Title X funding would disproportionately limit the access of young women of color to full and complete health care.

* * *

THE NATIONAL MEDICAL ASSOCIATION, founded in 1895, represents 16,000 Black physicians in the United States, including Puerto Rico and the Virgin Islands. The National Medical Association seeks to foster the enactment of just medical laws and to educate the public concerning all matters affecting public health, especially matters affecting the socio-economically disadvantaged and the health care of women. The National Medical Association supports the common struggle for reproductive choice and the equality of women.

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA

WEST VIRGINIA ASSOCIATION OF COMMUNITY HEALTH CENTERS, ET AL.

Plaintiffs,

v. C.A.____

LOUIS SULLIVAN, SECRETARY, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES,

Defendant.

AFFIDAVIT

I, Bruce Berry, M.D., depose and say:

1. That I am Vice Chairman of the West Virginia Section of District 4 American College of Obstetricians and Gynecologists ("ACOG").

2. That I have been Vice Chairman since 1986, and an active member in ACOG since 1973 as a Junior Fellow and a Fellow

since 1978, and board certified in obstetrics and gynecology since 1978.

3. That I submit this affidavit in support of the motion to enjoin implementation of regulations promulgated by the United States Department of Health and Human Services under Title X of the Public Health Service Act. I submit this affidavit in my capacity as the Vice Chairman of the West Virginia Section of District 4 of ACOG, a National medical association of more than 27,000 physicians specializing in the delivery of health care to women.

4. That the West Virginia Section of ACOG has taken a position against implementation of the previously described regulations, and that the position of the West Virginia Section is the same as that set forth by the affidavit of George W.

Morely, President of American College of Obstetricians and Gynecologists. (Commonwealth of Massachusetts v. Otis Bowen, United States District Court for the District of Massachusetts, Civil Action No. 88-0253-S, February 9, 1988), which is attached and herein incorporated.

5. That if Title X regulations prohibit post-pregnancy counseling, or clinics lose their Title X funding, many poor teenage family planning clients would not have available to them a full range of pregnancy counseling services including options counseling. Thus denied complete medical care, such clients would be deprived of the benefits of Title X Public Health Services previously delivered.

6. That given the demographics of West Virginia, to the extent that any Title X clients would have sought abortion

services, the provisions of these services will be thwarted altogether or delayed to a more hazardous stage of a woman's pregnancy.

7. That given my understanding of who could be on the referral list, it appears that a doctor would feel an obligation to counsel a pregnant women on all her options, including abortion, that that doctor could not be on the referral list and that would caused a great ethical concern for the physicians in the community.

8. That the ramifications of the implementation of the regulations are especially devastating to the obstetrics and gynecological community in West Virginia in that in the last five years the number of obstetricians and gynecologists in West Virginia has been

greatly reduced from 130 to 80. The regulations would place a heavy burden on the remaining obstetricians and gynecologist in West Virginia because it would force many Centers to close and encourage competent physicians to leave the State.

I declare under penalty of perjury that the foregoing is true and correct. Executed on this 22nd day of March, 1989.

/s/ Bruce Berry, M.D.
Bruce Berry, M.D.

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

COMMONWEALTH OF MASSACHUSETTS, ET AL.	
Plaintiffs,	
v.	C.A.
OTIS R. BOWEN, SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES	
Defendant.	

AFFIDAVIT

I, Diane M. Booth, depose and says:

1. That I am the Executive Director of Planned Parenthood of Central Missouri ("PPCM").

2. That I have served in this position for fifteen months.

3. That PPCM receives money under the U.S. Department of Health and Human Services' Title X family planning services

program as a delegate agency of the Missouri Community Health Corporation.

4. That the Title X funding in fiscal year 1987 represented seventeen percent (17%) ($168,000) of PPCM's operating budget.

5. That PPCM operates four clinics -- in Columbia, Jefferson City, Fulton, and Moberly -- covering ten counties.

6. That the Columbia clinic that provides a full range of family planning services also provides abortion services as well as housing PPCM's administration offices.

7. That the Columbia clinic is the only facility providing first trimester abortion services between Kansas City and St. Louis.

8. That the Columbia facility consists of one building, with one waiting

room, one reception area, one laboratory, one parking lot, and one entrance in operation (there is a second entrance to the building that is not in use).

9. That the Medical Director of PPCM provides abortion services at the Columbia clinic, and that some of the health professional staff also rotate between family planning and abortion services.

10. That PPCM has one personnel, accounting, and payroll system for all of its operations.

11. The PPCM currently prevents Title X funds from being used to fund abortion services by requiring staff to keep detailed time sheets and by allocating program income used for overhead costs by a cost allocation plan.

12. That if it were a requirement of the Title X program that abortion services

be totally separated (including total physical separation), PPCM would be forced to find another building for its abortion services, hire new staff, and reconfigure its administrative systems -- an extremely expensive venture.

13. In the event that total separation of services is required at the Columbia clinic, it is likely that PPCM would opt not to receive Title X funding, thereby reducing the opportunity for low-income people to receive family planning services.

14. That discussions with a number of the health care professionals on my staff indicate that they believe a ban on post-pregnancy counseling would force them to violate their medical ethics as well as expose them to medical malpractice liability.

15. That it would be impossible for PPCM to run a Title X program with a ban on post-pregnancy counseling in place because my staff would refuse to work under those conditions.

I declare under penalty of perjury that the foregoing is true and correct. Executed on this 14th day of December 1987.

/s/ Diane M. Booth
Diane M. Booth

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

COMMONWEALTH OF MASSACHUSETTS, ET AL.
Plaintiffs,
v. C.A.
OTIS R. BOWEN, SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Defendant.

AFFIDAVIT

I, Karen Cody Carlson, depose and say:

1. That I am the Executive Director of Planned Parenthood of Greater Kansas City ("PPGKC").

2. That I have served in this position for two years and three months.

3. That PPGKC receives money under the U.S. Department of Health and Human Services' Title X family planning services

program as a delegate agency of the Missouri Community Health Corporation.

4. That the Title X funding in fiscal year 1987 represented nine percent (9%) ($200,000) of PPGKC's operating budget.

5. That approximately 65% of the 15,000 clients seen last year received at least some subsidization under Title X.

6. That PPGKC operates four clinics covering the Kansas City metropolitan area and another clinic in Warrensburg, approximately 50 miles away.

7. That the largest of the Kansas City clinics provides a full range of family planning services as well as abortion services up to fourteen weeks of pregnancy.

8. That the Medical Director of PPGKC performs abortions in the Kansas City clinic, and several of the professional

staff rotates between family planning and abortion services.

9. That the co-located facility consists of one building, with one waiting room, one reception area, and one entrance in operation.

10. That PPGKC has one personnel, accounting, and payroll system for all of its operations.

11. That PPGKC currently prevents Title X funds from being used to fund abortion services by requiring clinic staff to keep detailed time records and by allocating overhead costs by budget and square footage as well as the salary for the Director of Patient Services by either budget or actual time spent on either service.

12. If the Title X regulations required that abortion services be totally

separated (including total physical separation), PPGKC would be forced to find another building for its abortion services, hire new staff, and reconfigure its administrative systems -- an extremely expensive venture.

13. In the event that total separation of services is required, it is very likely that PPGKC would opt not to receive Title X funding and require all patients to pay at least a partial percentage of the shares for services, thereby reducing the opportunity for low-income people to receive family planning services.

I declare under penalty of perjury that the foregoing is true and correct. Executed on this 18th day of December 1987.

/s/ Karen Cody Carlson
Karen Cody Carlson

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA

WEST VIRGINIA ASSOCIATION OF COMMUNITY HEALTH CENTERS, ET AL.

Plaintiffs,

v. C.A.____

LOUIS SULLIVAN, SECRETARY, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES,

Defendant.

AFFIDAVIT

I, Catherine Groom, depose and say:

1. That I reside at 1415 Third Avenue, Charleston, West Virginia 25312.

2. That I am 25 years of age and have been a patient at the Women's Health Center of West Virginia, Inc. (the "Center") since 1983.

3. That my expectation has always been that I would receive the same

treatment at the Center as I would from a private gynecologist.

4. That part of that expectation as to service if it was determined that I was pregnant, would be discussions with a counselor about the health consequences of my pregnancy, what my options and alternatives are, and where I could go for further treatment. I am especially concerned about the regulations because it is my understanding that I may be at risk to have another child. If I were to become pregnant, I would want immediate counseling about my options.

5. That if I were told that I was pregnant and was then simply handed a list of prenatal health care providers with no explanation or discussion, I would have no way of evaluating the names on that list and would have no idea which name I should

go to see for counseling and information. I would feel frustrated and mad.

6. That I have in the past recommended to people whom I know that they use the Center precisely because the staff at the Center provides complete information and counseling to people with low incomes.

7. That if the Center no longer were to provide post-pregnancy counseling, I would not go to the Center, and I would tell people that I know not to go to the Center.

I declare under penalty of perjury that the foregoing is true and correct. Executed on this 22 day of March, 1989.

/s/ Catherine Groom
Catherine Groom

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA

WEST VIRGINIA ASSOCIATION OF COMMUNITY HEALTH CENTERS, ET AL.	)	
Plaintiffs,	)	
v.	)	C.A.____
LOUIS SULLIVAN, SECRETARY, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES,	)	
Defendant.	)	

AFFIDAVIT

I, Margie F. Hale, depose and say:

1. That I am Executive Director of The Women's Health Center of West Virginia, Inc. ("The Center").

2. That I have been its Executive Director since May 1987. My duties at The Women's Health Center are supervision of the day-to-day operations of the Center, including responsibility for personnel

management, financial affairs and public relations.

3. That the Center serves Kanawha County for family planning services.

4. That other than family planning services, the Center also provides obstetrics and gynecological services; birth services; family and individual counseling; abortions, and case management for pregnant teens, which includes counseling and assistance for those clients who wish to have their babies and keep them. Assistance includes housing, post birth medical care, transportation for pre-natal care, etc.

5. That the Center receives funds under the United States Department of Health and Human Services Title X Family Planning Services Program as a delegate

agency of the West Virginia Department of Health.

6. That in fiscal year 1988, the Center's Title X grant was $62,000, which represents 8.3% of the Center's $750,000 total operating budget.

7. That the Center served 2,000 unduplicated family planning clients during 1983. Because of the limited number of practitioners, the Center is not able to meet the need for family planning services in this area.

8. That if Title X regulations ban the co-location of family planning services and abortion services, the Center would terminate its family planning services. The Center would not conduct a family planning program which is prevented from counseling clients on the full range of family planning options because such

counseling would violate well accepted medical ethics as observed by our Staff. Additionally, it is not economically feasible for the Center to open separate facilities for our family planning-related services on the one hand and our abortion-related services on the other.

9. That in 1988, the Center performed 555 pregnancy tests of which 42% were positive. The clients who have had pregnancy tests frequently immediately ask us questions about what options are available to them with respect to their pregnancy.

10. That the health professionals on my staff feel that a ban on post-pregnancy counseling involving a full range of options would force them to engage in unethical medical practices.

11. That if Title X regulations banned the full range of post-pregnancy counseling respecting options, the Center would find it exceedingly difficult to continue to provide Title X services because qualified health care professionals would not agree to work for the Center.

12. Our clients who are told that they are pregnant expect to discuss the consequences of their pregnancies and their options with my staff. If we provided no post-pregnancy counseling or limited post-pregnancy counseling, our clients would feel frustrated and angry and would likely not return to the Center and would tell other people not to use the Center's services.

13. That the Women's Health facility consists of two offices side by side with

one unrelated office between them. One office is used solely for the Birthing Center and the other office is used for all other services provided by the Center, including family planning, gynecological service, counseling and abortions.

14. That the Center has one personnel system, one accounting system, and one payroll system for all of its operations.

15. That the Center has been able to comply with Section 1008's prohibition on the use of Title X Federal funds to advocate family planning by several methods: (1) the Center does not and has never advocated abortion as a means of family planning; (2) abortion and family planning are never offered at the same time; (3) separate patients records are maintained for family planning clients and abortion clients; (4) the primary staff

involved in abortions on the one hand and family planning on the other are different individuals.

16. That the Women's Health Center has never been found to violate the Federal statute heretofore and our activities have always been consistent with the requirements of the Department of Health and Human Services.

17. That if the Title X regulations require that abortion services be totally separated physically and financially from the family planning services offered by the Center, the Center would be required to find another building for one or the other of its services, hire new staff, reconfigure its systems, all of which are beyond the financial wherewithal of the Center.

18. All Title X funds are used exclusively in the family planning program and not in the provision of abortion services.

I declare under penalty of perjury that the foregoing is true and correct. Executed on this 22 day of , 1989.

/s/ Margie Hale
Margie F. Hale

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

COMMONWEALTH OF MASSACHUSETTS, ET AL.
Plaintiffs,
v. C.A.
OTIS R. BOWEN, SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Defendant.

AFFIDAVIT

I, Leslie Tarr Laurie, depose and say:

1. That I am the Executive Director of Family Planning Council of Western Massachusetts ("FPCWM").

2. That I was the founder of FPCWM and have been its Executive Director for fifteen years.

3. That FPCWM receives money under the U.S. Department of Health and Human

Services' Title X family planning services program directly from HHS.

4. That the Title X funding in fiscal year 1987 was $564,664, representing approximately forty percent (40%) of FPCWM's operating budget.

5. That FPCWM served approximately 13,000 clients in the past year. There are an estimated 45,000 clients our service delivery area that are in need of affordable family planning services.

6. That FPCWM operates eleven clinics covering 3000 square miles in Western Massachusetts. In many of the rural areas, FPCWM's clinics are the only source of reproductive health care available.

7. That in all of its clinics, FPCWM provides comprehensive family planning services. Two of its clinic sites are co-

located with other organizations that provide abortion services.

8. That if Title X regulations banned the co-location of family planning with abortion services, FPCWM would be forced to terminate family planning services in two geographical areas because it would not be economically feasible to open separate facilities.

9. That in 1986, FPCWM performed 2738 pregnancy tests.

10. That conversations with health professionals on my staff indicate that they believe a ban on post-pregnancy counseling would force them to engage in unethical practices.

11. That if Title X regulations banned any post-pregnancy counseling, FPCWM would find it exceedingly difficult to continue to provide Title X services because

qualified health care professionals would refuse to work for FPCWM.

12. That our clients who are told that they are pregnant expect to discuss the consequences of their pregnancies and their options with our staff. If FPCWM provided no post-pregnancy counseling, clients simply given a list of prenatal health care services would feel frustrated and angry. They would most likely not return to FPCWM and would tell other people not to use FPCWM's services.

I declare under penalty of perjury that the foregoing is true and correct. Executed on this ___ day of December 1987.

/s/ Leslie Tarr Laurie
Leslie Tarr Laurie

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF WEST VIRGINIA

WEST VIRGINIA ASSOCIATION OF COMMUNITY HEALTH CENTERS ET AL.	)	
Plaintiffs,	)	
v.	)	C.A.
LOUIS SULLIVAN, SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES	)	
Defendant.	)	

AFFIDAVIT

I, Susan B. Walter, depose and say:

1. That I am the Executive Director of Shenandoah Community Health Center of Intercounty Health, Incorporated.

2. That I have been its Executive Director for 3-1/2 years.

3. That I received a Master in Social Work from West Virginia University and have worked as an administrator in the

community health field for the past nine years.

4. That Shenandoah Community Health Center is a community health center providing comprehensive health care services to all in the community regardless of their ability to pay. Patients served by Shenandoah Community Health Center reside in Berkeley, Jefferson, Morgan, Mineral, Hampshire, and Hardy counties of West Virginia. Between June through November each year Shenandoah Community Health Center also provides health care services to migrants and seasonal farmworkers in those same West Virginia counties and in northwestern Virginia and Maryland.

5. That Shenandoah Community Health Center's focus is on prevention, education, and managed care.

6. That in 1988 Shenandoah Community Health Center served 12,729 patients with 47,907 patient visits for medical care, social services, and WIC nutrition services. 2,825 of these patients were migrant and seasonal farmworkers with limited or no fluency in English or access to health care.

7. That the Shenandoah Community Health Center receives Title X funding through the West Virginia State Department of Health, which in turn receives its Title X funding from the U.S. Department of Health and Human Services.

8. That most family planning services provided to the clients seen by Shenandoah Community Health Center are subsidized, at least in part, by Title X.

9. That last year Shenandoah Community Health Center provided Title X

family planning services to 1,446 clients with over 2,950 visits. 725, 50%, of these clients were 19 years of age and under.

10. That in 1988, Shenandoah Community Health Center performed approximately 1,200 pregnancy tests.

11. That Shenandoah Community Health Center health professionals indicate that they believe a ban on post-pregnancy counseling would force them to engage in unethical practices.

12. That if Title X regulations banned any post-pregnancy test counseling, Shenandoah Community Health Center would find it exceedingly difficult to continue to provide Title X services because qualified health care professionals could not violate their professional ethics by withholding information from patients and

by not responding to patients' requests about their options.

13. That Shenandoah Community Health Center could not afford to organize the physical, financial, personnel and record keeping separation required by the new Title X regulations.

14. That it is my understanding that by not providing a continuity of comprehensive health care information to our patients, Shenandoah Community Health Center would violate the intent of Public Health Service 329 and 330 funding, major funding sources for Shenandoah Community Health Center.

15. That I, as an Executive Director of a community health center, am pledged to advocate for the needs of the medically underserved and am responsible for ensuring the provision of quality

comprehensive health care services to all Shenandoah Community Health Center patients. Denying a continuum of information and services to a particular group of patients would be discriminatory and would violate my leadership and personal integrity.

I declare under penalty of perjury that the foregoing is true and correct. Executed on this 21st day of March, 1989.

/s/ Susan B. Walter
Susan B. Walter, M.S.W.
Executive Director

STATE OF WEST VIRGINIA

COUNTY OF BERKELEY:

Subscribed and sworn before me this 21st day of March, 1989.

June N. Cutlip, Notary Public

My commission expires August 21, 1991.